NORTH CAROLINA MEDICAID

Procrit / Epogen Prior Authorization

Request Date _____

Recipient's Medicaid ID# _____ Date of Birth _____/_____/_____

Recipient's Full Name _____

Prescriber Full Name _____

Prescriber DEA # _____ Prescriber Telephone # _____

Prescriber Fax _____

Prescriber E-mail Address _____

Prescriber Address (mandatory) _____

City _____ State _____ Zip _____

Drug Strength / NDC (If available) submitted on claim _____

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1. What is the diagnosis or the indication for the product:
   - ( ) Anemia associated with renal failure if patient is **not** on dialysis
   - ( ) Anemia associated with HIV infection
   - ( ) Anemia associated with chemotherapy
   - ( ) Blood transfusions, allogenic, in anemic surgery patients
   - ( ) Other _____

2. Is this New Therapy ( ) or Continuation of Therapy ( )?

3. Does the patient have gastrointestinal bleeding?
   ( )Yes ( ) No

4. For surgical patients, is the patient willing to donate blood?
   ( ) Yes ( ) No

5. Lab Test Date (Dated within the last 3 months): _____

   Hematocrit: _____% Hemoglobin: _____g/dl

6. What is the dosage and frequency of dosing? _____

Instructions to submit: (Choose one)

To Fax or Mail:

1. Form may be completed electronically or handwritten.
2. Fax or mail to ACS State Healthcare.

To Email:

1. Save the form using a different filename.
2. Complete electronically.
3. Email as an attachment to ACS State Healthcare.

Send to:
ACS State Healthcare, Prescription Benefits Management
Prior Authorization Dept.
Northridge Center One, Suite 400
365 Northridge Road
Atlanta, GA 30350
Fax: (866) 246-8507
Phone: (866) 246-8505; M-F 7am-11pm, EST; S-S 7am-6pm, EST
E-mail: nc.providerrelations@acs-inc.com

FOR AFFILIATED COMPUTER SERVICES (ACS) USE ONLY

Date: _____ Notified: _____

Approved: _____ Denied: _____

Reason: _____

March 2002